Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GERALD A HALIBY, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name
ULLICO CASUALTY CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-12-2698-01

MFDR Date Received
April 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Insurance Carrier did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16, 2011	99456-W5-NM	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for the reimbursement of workers' compensation specific services rendered on or after March 1, 2008.
3. 28 Texas Administrative Code §133.250 sets out guidelines for reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §133.20 sets out the guidelines for a medical bill submission by a health care provider.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Neither the requestor nor the respondent submitted explanations of benefits.

Issues

1. Did the requestor request reconsideration from the respondent in accordance with 28 Texas Administrative Code §133.250?

2. What are the guidelines for reimbursement of a MMI exam in accordance with 28 Texas Administrative Code §134.204?
3. Did the requestor submit a bill in accordance with28 Texas Administrative Code §134.204?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.250 (c)(1-2) states, "(c) A health care provider shall not submit a request for reconsideration until: (1) the insurance carrier has taken final action on a medical bill; or (2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier. Review of the requestor's documentation finds a fax transmittal for the requestor's reconsideration request dated February 14, 2012. The reconsideration letter indicates that the requestor did not receive an explanation of benefit (EOB) in response to their original bill submission within 50days and therefore, are requesting reconsideration and a copy of the original EOB. This documentation sufficiently supports that the requestor submitted a bill to the respondent in accordance with 28 Texas Administrative Code 133.20 and 28 Texas Administrative Code 133.250(c)(2). Therefore, disputed service will be reviewed in accordance with the applicable DWC Rules.
2. 28 Texas Administrative Code §134.204(i)(B) states, "Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor." 28 Texas Administrative Code §134.204(j)(2)(A) states, "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added." 28 Texas Administrative Code §134.204(j)(3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."
3. The requestor billed using CPT Code 99456-W5-NM for a Division ordered exam to determine maximum medical improvement (MMI). The medical records support that an MMI exam was completed on November 16, 2011. The requestor determined that the injured employee was not at MMI. Therefore, the Division concludes that the requestor appropriately submitted a bill to the respondent for CPT code 99456-W5-NM in accordance with 28 Texas Administrative Code §134.204(j)(2)(A) & 28 Texas Administrative Code §134.204 (j)(3)(C).
4. Reimbursement of $350 is recommended in accordance with 28 Texas Administrative Code §134.204 (j)(3)(C).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/25/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box

17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.